

Psychiatry in geriatric practice

Geriatricians are aware of the high prevalence of psychiatric disorder in old age. They know how often the acutely confused are so because of an underlying physical disorder which they can detect and treat. They can distinguish between such delirious states and dementia and give the right prognosis and management. They can often identify depressive illness, which according to Kay, Beamish and Roth (1964), is present to some degree in a quarter of the elderly population, where it accompanies or even mimics physical disease. They have an awareness of social medicine. They are prepared to visit the patient at home to make a social as well as a medical diagnosis, recognize the hazards and assets in the home and deploy the full range of domiciliary services. They are well aware of the dangers of iatrogenic disorder in the elderly and thus avoid overtreatment as well as undertreatment. For example, they can estimate how likely a patient is to take any tablets prescribed and they are very clear about what the prescription is supposed to achieve.

The role of all doctors in treating the old

The geriatrician is energetic but patient, and reluctant to accept the chronicity of any disorder. He uses physiotherapy and occupational therapy to the full in rehabilitation, and gets keen pleasure from a small but significant change in his patient's condition towards greater independence, as well as from dramatic cures. He is firm but humane, kind without sentimentality. It helps enormously if he has a sense of humour. This paragon, however, is in short supply and much abused. For too long he has been kept out of the teaching hospital and has had to practise in the oldest and least well equipped accommodation. He has too few staff, of indifferent calibre. His wards are dumping grounds for other doctors' failures. The patient discharged with unthinking heartlessness from a medical or surgical bed is referred to him next day after a night of suffering. His advice is sought on 'disposal' which means 'take over', and he is blamed and resented if the patient is not swiftly moved. Even psychiatrists have been known to try to make him responsible for otherwise fit demented patients, arguing that brain disease (despite considerable behaviour disorder) is the concern of the geriatrician rather than of the psychiatrist.

The prevalent antipathy to aging and the aged means that patients are referred to the geriatrician late in the course of their illness, that there is considerable resistance to their discharge, despite successful treatment, and that the best doctors are not often attracted to the specialty. Small wonder that some geriatricians are lonely and embittered!

Geriatrics is not the answer to old age when it is used by other doctors to evade their responsibilities

for their own elderly patients. By so doing they fail to develop or to impart any experience in dealing with the elderly themselves. Geriatrics is too important to be left to the geriatricians.

Reference

- Kay, D W K, Beamish, P, and Roth, M (1964). Old age and mental disorders in Newcastle-upon-Tyne. *British Journal of Psychiatry*, 110, 146-158.

III Attitudes

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Youth versus age when money is scarce

A contingency plan drawn up by a major regional hospital to deal with a possible cutback in funding or a staffing crisis resulted in a reluctant decision that the psycho-geriatric unit would have to be the first to be closed down. This decision will come as no surprise to those concerned with the elderly, or the field of mental health in a work-ethic society, who have become well used to being last in line for resources, new buildings, or the benefits of technology associated with high-status medicine.

Another manifestation of the same syndrome is to be found in the current debate over unemployment, where there is general agreement that all new plans and programmes must be concentrated on meeting the needs of young school leavers at the thresholds of their careers; whereas those who are older are expected to make their contribution by sacrificing themselves on the altar of premature retirement. In this particular context, the fact that the older worker may actually be more productive, so that his output could accelerate the process of industrial recovery on which everyone's future depends, is considered to be of less consequence than occupying the young. Their anger at a sense of irrelevance, boredom, or uselessness is more likely to erupt into frightening violence than that of older workers who have had a lifetime's experience in containing their feelings.

The health service administrators concerned with the hospital contingency plan in the first illustration, or the politicians and their advisers seeking to stabilize the economy in the second, who both appeared to devalue the intrinsic quality of older life, were not in themselves heartless or unfeeling people (they probably treat their own grandparents with respect and affection). Nor were they acting in face of public opinion because their decisions reflect the general ethos of the society of

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which they are a part, the same society, which if asked to decide upon the allocation of a rare piece of life-saving hardware, would always rate future prospects and potential more highly than past achievement.

Although these approaches are consistent with a pluralist secular society, where spiritual values assume less significance than those which can be measured in terms of cost benefit analysis, it is perhaps disturbing that they should also have penetrated so deeply into the attitudes of those in the caring professions who administer the health and social services. They should understand that aging does not diminish creative urges for personal fulfilment and the need for the individual to continue to sustain a creative role within his community, however narrow and restricted circumstances may have forced it to become.

Physicians, priests and social workers should know that radicalism, adaptability to change and personal development are not the prerogative of youth. But many of them appear to have forgotten as they have become caught up in the universal coffee-bar cult which has dominated so much social planning since the mid-fifties. Perhaps this goes back to their own training where, for example, the amount of time devoted to the teaching of geriatrics in the majority of medical schools has been minimal in relation to many other disciplines. In one regional teaching hospital the time allocated is 30 hours only. But this is considered generous in some quarters, although with the involvement of a number of gifted, reforming physicians and the creation of an increasing number of chairs in geriatrics, the situation is improving. However, geriatrics is still very far from occupying the position of other branches of medicine, in spite of the fact that with a universal life expectancy moving into the mid-70s, elderly patients and the diseases associated with aging are likely to absorb more time and energy on the part of general practitioners than any other aspect of their knowledge, apart from the act of childbirth. In the same way, the schools of social work can often find little time in their curricula, apart from a few peripheral sessions, to consider the multiple socio-economic needs of the elderly whereas sequences on child growth and development may well span a year or more. However, this organizational deficiency does not happen in a vacuum. It is a reflexion of a society, in which the extended family, with its clearly defined grand-parental roles, is now largely an anachronism.

The rejection of aging

But perhaps there is another factor to be considered in terms of the fundamental self-rejection of aging amongst young people, epitomized in one of the slogans adopted by a recent campaign based on the concept of 'young on the inside', a copywriter's

catch phrase designed to indicate that grannie's external wrinkles somehow disguise a young spirit, as though that in itself has some virtue. But the distasteful manifestations of 'agism' are frequently exploited in advertising where purchasing power and sexuality are closely related.

This rejection of aging, which is as evident amongst young doctors as in other sectors of society, is rationalized if it leads to a reluctance to practise amongst old people, by assumptions that there are few, if any, clinical satisfactions to be derived from treating elderly patients who may perversely refuse to respond to the high technology of modern medicine by recovering and in adopting alternative solutions. In social work the variant on the same theme would be to describe the lack of creative solutions to problems amongst elderly clients. Whilst the social worker's training in sensitivity may have provided a thin veneer of disguise to hide this attitude, there are many elderly patients who have given up going to their doctors on the basis that all they have come to expect, when describing their difficulties, is the somewhat curt and negative comment that (whatever it is) 'is all that can be expected at your age'. In such circumstances, it is not surprising that many elderly people feel, as did one interviewed in an Age Concern survey about the use she made of her general practitioner, by saying that she did not like to trouble him. In common with so many of her generation her expectations were very low. When many pensioners are asked to define satisfaction in terms of available income, the provision of services, health or personal comfort they are often pathetically grateful for a depressed level of which only those who had endured longstanding deprivation would find tolerable.

A growing regiment of pensioner-voters

This situation will change for the better as new generations of better educated and more sophisticated people retire. They will be far more spirited than many of the present generations of pensioners, born in the late nineteenth century or shortly after, who still retain cruel memories of the harsh administration of the Poor Law and of the degradation involved in seeking any form of public assistance, care, or treatment, in a system riddled with value judgments. This historic factor, for example, probably accounts for the fact that about three-quarters of a million retirement pensioners do not claim the supplementary benefits to which they are entitled. Research has suggested that, although about half are still ignorant of their eligibility, as many again do not apply simply through pride because for them supplementary benefit and parish relief are part and parcel of the same process. The new pensioners will understand how the system operates. They will accept that they have rights and they will

be better able to make their presence felt through personal intervention as well as through corporate action. There is evidence that this is already happening quite extensively in the United States where powerful and politically active associations of the retired – both white and blue collar – having more than ten million members between them, who are also voters, are beginning to flex their political muscles and make themselves felt both on Capitol Hill as well as within the state legislatures. It is only a matter of time before the retired come to realize that by the sheer weight of their numbers they could well become a potent force to match up to the powerful industrial and trade union lobbies. They could have far more influence on government than a relatively small group of noisy young students.

This new factor, therefore, suggests two things. First, that there needs to be a very profound change in attitude towards aging, devoid of pity and false sentimentality, but also free of the rejection which is suffered by those who are no longer economically active. The trouble with stereotypes (and the elderly suffer very much from the Darby-and-Joan, silver-threads, golden-shreds syndrome) is that people begin to assume the role which society assigns them. So that if they are expected to be passive, acquiescent, grateful, humble, conformist, this is what they will become in compounding the sense of their own worthlessness.

The manifesto by Age Concern on the place of the elderly and retired in modern society

Age Concern published a manifesto on the place of the elderly and retired in modern society in 1975. Amongst the list of the preconditions for a full and satisfying life designed to enable the individual to exercise choice, a feature which the aging process erodes by its nature, self determination and participation in the decision-making processes were amongst the key factors, as was avoidance of the paternalism associated with so much institutional care in hospitals and homes which create dependency and a sterile kind of existence. There the patients are surrounded by 'safety nets' designed for the convenience of the providers rather than for the comfort and freedom of the consumers, who might find stimulus in a life involving some taking of risks. The manifesto also covered basic issues in relation to adequacy of income, housing, transport, service delivery and recreation for those who wished to continue to participate although it also acknowledged the right of the individual to disengage without feelings of guilt and inadequacy.

But perhaps the key passage in this document was the stress it laid on the powerful force which *enlightened self interest* has had on social change and reform. The point in time at which the providers of service begin to perceive themselves as consumers has always marked a critical stage in radical change.

It happened in education as well as in the maternity and child care services. Now it has to happen in relation to the elderly, so that doctors and social administrators, housing managers, politicians and voluntary workers would be content to use the facilities they currently offer to others but insure against using for themselves. This is not an argument based upon political dogmatism, but upon the acknowledgement that aging is a universal process and that the elements upon which personal fulfilment depend may differ in emphasis or degree but their roots are constant.

Generosity among professionals in caring for the elderly

Improvements in the quality of life for the elderly do not depend solely upon change in attitudes or even on enhanced provisions, important though these are. There is also the vital question of broadening the actual basis of knowledge of those who serve the elderly about the wide range of benefits which are, or should be, available, so that, for example, the doctor is aware of the whole range of public and voluntary agencies in the community which can be brought to bear on the problem-solving process, as well as knowing the multiplicity of income benefits. In crude terms, a diagnosis which suggests vulnerability to a hypothermic condition in an elderly patient, for which the prescription is warmth, mobility and an improved diet, is pointless for someone living in atrocious housing conditions, with no public transport, a dearth of home helps and an unaugmented income. This may suggest that the doctor should join with the social activists if he is to serve his patients; but with an increasingly complex society no single professional service can be provided in a vacuum. Perhaps medicine, above all, needs a multidisciplinary approach, recognizing the interlocking socio-medico problems which have to be treated and administered jointly on a basis of generosity between many professionals. This has not always been in evidence during the last decade with its sequence of reorganizations and the emergence of new professional disciplines in which openness and sharing have been less evident than aggression and defensiveness on the part of many people.

It may be argued that the principles of a corporate approach already exist through the concept of general practice as the team of primary care in the support group surrounding the consultant, and in the consultative mechanisms now linking the National Health Service with local government. But it is far from universal: it still assumes that the doctor must be the pivotal figure and this does not suggest a corporate approach amongst equals and still excludes many key elements: for example, the architect, the planner, the transport manager, the food manufacturer and retailer, the housing

manager, the supplementary benefits officer, the priest and many more.

If a new level of cooperation is to emerge in practice the process has to begin where professionals learn their craft and where opinions are formed, so that understanding and respect become deeply ingrained in order to avoid confrontations or failures to encounter later, in the belief that multiple problems can only be resolved by the interplay of multiple solutions. There are really

very few medical problems amongst the elderly which do not have a major social element, and a social problem is, by its nature, the sum of a number of problems or calamities which play and feed upon each other, none of which can be resolved in isolation and few of which respond to a single isolated course of treatment ignoring a whole range of environmental factors which often militate against cure, but which if properly organized can be the means of finding acceptable and creative solutions.